



# Meanings, Policies, and Medicine: On the Bioethical Enterprise and History

## Citation

Rosenberg, Charles E. 1999. Meanings, policies, and medicine: On the bioethical enterprise and history. *Daedalus* 128(4): 27#46.

## Published Version

<http://www.jstor.org/stable/20027587>

## Permanent link

<http://nrs.harvard.edu/urn-3:HUL.InstRepos:4730333>

## Terms of Use

This article was downloaded from Harvard University's DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at <http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA>

## Share Your Story

The Harvard community has made this article openly available.  
Please share how this access benefits you. [Submit a story](#).

[Accessibility](#)

## Meanings, Policies, and Medicine: On the Bioethical Enterprise and History

ONE CAN HARDLY IGNORE the widely shared conviction that we are living through a period of crisis in health care. And that crisis is more than economic and administrative, though its most egregious symptoms present themselves in these interrelated forms. One need only pick up a newspaper or magazine to be reminded of the omnipresent and multidimensional nature of the problems confronting American medicine. Many of those perceived dilemmas turn on rapid technical change and the difficulty of creating an institutional and economic, as well as moral, context in which these new clinical, policy, and research options can be managed. Not surprisingly, bioethics is often invoked—as both symptom and possible remedy—in discussions of these jarring realities. How are we to think about this enterprise, site it in social space, and understand its several interrelated identities? These are not easy tasks. Contemporary bioethics constitutes a particularly elusive challenge for the historian; value assumptions have always shaped medicine as a social enterprise, yet those values have been often implicit and unspoken, the moral common sense of each generation interacting with technical, professional, institutional, and economic factors to configure a time-specific set of clinical realities.

---

*Charles E. Rosenberg is Janice and Julian Bers Professor in the department of the history and sociology of science at the University of Pennsylvania.*

## MEDICAL CARE AND SOCIAL OBLIGATION

For this historian of American medicine, some of the markers of contemporary change are particularly striking. The *New York Times*, for example, reported in 1998 that Montefiore Hospital had announced its intention of entering into a joint venture with a for-profit corporation; it planned to open a chain of 24-hour cancer and HIV clinics. "The No. 1 problem for not-for-profit institutions," the president of Montefiore explained, "is capital formation."<sup>1</sup> In my own city, Philadelphia, the Pennsylvania Hospital, America's oldest general hospital, first sold its historically important psychiatric division to a for-profit provider, then sold itself, after an independent existence of a quarter of a millenium, to a rather more youthful entity called the University of Pennsylvania Health System, which announced its plans to send four "experts in 'clinical reengineering' to look for ways to make cost-effective changes in clinical care" at its new acquisition.<sup>2</sup> The Hospital of the University of Pennsylvania had just finished its own "reengineering." Even more recently, the Philadelphia region's health-care system has been destabilized and demoralized by the aggressive takeover strategy of a Pittsburgh-based health-care system, which purchased physician practices, hospitals, and associated medical schools in a bold marketplace venture that soon ended in bankruptcy, unmet commitments, and a perilous future for such historically significant institutions as Hahnemann Medical College and the Medical College of Pennsylvania.<sup>3</sup>

Particularly revealing among my collection of recent media indicators is an ironic—and enlightening—juxtaposition of stories on the front page of the *New York Times*.<sup>4</sup> In the upper right-hand corner was a report that National Institutes of Health (NIH) funding was likely to be increased in next year's budget. And, it was explained, cancer could be understood and treated. "We are in a golden age of discovery," the director of the National Cancer Institute (NCI) contended, "one unique in human history. . . . Knowledge about the fundamental nature of cancer is exploding." Basic science was closing in on mankind's ancient enemy, and relentless Washington lobbying could be relied on to nurture this laudable enterprise. A coalition of

interested parties—patient advocacy groups, doctors, and medical schools—had joined in supporting an effort to double the NIH budget over the next five years. “We plan a grass-roots campaign inside and outside the Beltway,” the president of their lobbying firm explained candidly: “It will be run the same way Northrop Grumman lobbies for the B-2 bomber.” Immediately to the left of this upbeat and uninflected report of promised laboratory achievement was a background story on the emotional and physical pain associated with the multiple births resulting from contemporary fertility treatments: “Joy and Sorrow follow Medical Miracle” read one of the subtitles in this sobering overview.<sup>5</sup> Whether the placement of these stories on the front page of the *Times* was a compositor’s whim or an implicit editorial comment, the message seems undeniable. Technology, market incentives, and public policy have changed and are changing every aspect of medical care, while society has been less than successful in anticipating the consequences of such change.

The Fall 1998 special issue of *Life*, to cite a related example, was devoted to “Medical Miracles for the Next Millennium.” The cover promised “21 Breakthroughs That Could Change Your Life in the 21st Century: Gene Therapy/Edible Vaccines/Memory Drugs/Grow-Your-Own Organs.” Little attention was paid in the magazine’s worshipful depiction of laboratory progress to the ironic and seemingly paradoxical growth of a widespread fear of that technology’s human implications. Similarly illuminating was an issue of *Time* on “The Future of Medicine.” The subtitle promised to explain “how genetic engineering will change us in the next century.” The striking cover illustration was a stylized caduceus, a snake’s head morphing into a coil of DNA.<sup>6</sup> How better to symbolize medicine’s changing and conflicted shape in a world of relentless laboratory progress and media-heightened public expectations? The cover’s powerful visual metaphor represents as well two seemingly inconsistent yet mutually constitutive aspects of contemporary medicine: the technical and the sacred—the cultural power of laboratory novelty and the persistence of a self-conscious ethical tradition.

I would argue that this brief sampling of media reports provides a useful microcosm of a structural and emotional macro-

cosm. It illustrates not only a perceived crisis in public policy, but a fundamental inconsistency between values and expectations, as well as the concrete social and economic relationships in which such convictions and perceptions are necessarily embedded.

Our health-care system is marked by a characteristic disconnect: on the one hand, boundless faith in the power of the laboratory and the market, on the other a failure to anticipate and respond to the human implications of technical and institutional innovation. And this dilemma grows directly out of our expansive faith in technical solutions to clinical problems; as we are well aware, sickness, pain, disability, and death are not always amenable to clinical intervention. In the late twentieth century, such conflicts are both public-policy issues and, inevitably, elements in individual doctor-patient relationships. The question, of course, is relating the particular to the general, understanding the choices that face individuals in recurring social interactions—in some sense weighing and understanding degrees of individual autonomy, of professional and collective social obligation. I would contend that bioethics must ultimately address such questions and issues that are necessarily historical and unavoidably moral: the move from the individual to the social, from meaning to structure in terms of medicine, from the clinical encounter to the larger society in which that encounter takes place.

#### MEDICINE AND MEANINGS

To a historian, many of the dilemmas that beset contemporary medicine are strikingly different from parallel realities in previous American generations. The world of social value, and thus obligation, was very different, for example, when the Montefiore Home for Chronic Invalids opened its doors in 1884, and certainly when the Pennsylvania Hospital was established in the 1750s. Pious and paternalistic activism, the exchange of care for deference, were as central to the eighteenth- and early nineteenth-century hospital as monetary exchange was alien to it. Class and dependence as much as diagnosis determined one's place in a "system" of health care sited largely

in the home, and in which institutional care was limited essentially to the urban poor.<sup>7</sup> In fact, the late-twentieth-century term “health-care system,” with its assumption of a complex, multilayered, bureaucratic, interactive, and, by implication, public world of medicine, is irrelevant to an era without specialists and laboratories, an era in which the great majority of medical care was performed in the patient’s home, whether by family members or professional physicians. The worthy poor were presumed to deserve voluntary hospital care without incurring the stigma that came with almshouse admission. Physicians were presumed to have an obligation to provide gratuitous or discounted care to those unable to afford their fees. Whether rural or urban, nineteenth-century Americans were presumed to have a right to such care, but not, of course, to equal—class-blind—care.

The public sector played a role in the provision of health care, but only in regard to the dependent, not to those seen as able to care for themselves. A socially constructed sense of stewardship, of categorical moral obligation, motivated and shaped the efforts of our earliest hospitals’ founders. They did not expect to be judged primarily by the success or failure of marketplace decisions (though they were expected to function responsibly within the market). The medical profession was presumed, at least in theory, to be motivated by a code of gentlemanly and selfless benevolence; patenting discoveries—like advertising one’s clinical services—was, for example, seen as evidence of sordid quackery, not rational market behavior. Economic competition was understood to be not a guarantor of economically efficient health care but an ever-present motivation for misrepresentation and shoddy practice.

In 1800, medical ideas and medical practice were widely distributed throughout society—in patterns vastly different from those to which we have become accustomed in the late twentieth century. Conventional moral values suffused both lay and professional ideas of disease causation and treatment, for example, but were not legitimated in terms of modern notions of specific, mechanism-defined disease. Disease categories did not, logically enough, play so prominent a role in lay understandings of behavioral deviance, or in physicians’ understanding of

appropriate therapeutic and diagnostic choices. Homosexual behavior was a willed act of immorality, for example, not a disease, personality type, or merely one among a variety of lifestyle patterns; disruptive grammar-school children were wicked and undisciplined, not victims of Attention Deficit Hyperactivity Disorder. Death involved prognosis and pain, confrontation with a patient's spiritual and aggregate physiological status, not the management of machines and the hegemony of bureaucratic protocols and insurance schemes. Euthanasia meant literally that—an easy death—and implied the deployment of opiates, moral reflection, and family, not respirators and advanced directives.<sup>8</sup> Research had not yet come to embody a transcendence rivaling that of traditional religion and community obligation.

There are, of course, continuities as well as contrasts between the late eighteenth and the late twentieth centuries. Chronic disease, for example, posed questions of behavior, volition, and regimen—just as today's anxieties about risk factors and lifestyle mobilize feelings of guilt and accountability.<sup>9</sup> And men and women felt pain, feared death, mourned the loss of loved ones—as they still do.

My argument will have become clear enough by now. I have tried to illustrate in concrete terms the way in which morality and moralism, obligation and responsibility are unavoidable elements of medical care, and at the same time contingent and historical. Medical ideas and practices have always reflected, incorporated, and sanctioned prevailing notions of value and responsibility. Such ethical assumptions imply priorities and constrain choice; meaning and morality are thus necessarily and inextricably embedded in every aspect of medical practice: private and public, individual and collective.

#### NOVEL REALITIES

If anything can be said to characterize our particular moment in the relationships among the linked histories of medicine, culture, and public policy, it is, as I have emphasized, a novel sense of change and conflict, an uncomfortable awareness of the difficulties inherent in balancing the sacred and the techni-

cal, the individual and the collective, in configuring the rights of physicians, individual patients, and the general good. It was, in fact, out of such perceived conflict that bioethics itself developed as a self-conscious movement in the 1960s and early 1970s. Its very creation was in part a symptom—as well as a recognition—of perceived inequity, of a gap between medicine's presumably sacred and humane tradition and a reality often egregiously inconsistent. It was an acknowledgment that something needed to be done.<sup>10</sup>

In another sense, this gap between medicine's humane tradition and a more complex and compromising reality can be thought of as a structured crisis in supply and demand: a demand constituted by pain and anxiety and the inexorable realities of demography and chronic disease, yet routinely construed in terms of procedures and specialists.<sup>11</sup> Americans have produced a reservoir of insatiable clinical demand ill-suited to a world of supply dominated by technology, by impersonal—and costly—providers and products.

This asymmetry embodies a structured conflict that a minority of far-sighted social scientists and physicians have warned about since the progressive era at the beginning of the present century, when such critics deplored a growing medical impersonality and dependence on what they already saw as increasingly pervasive technology. Such anxieties might, in fact, be seen as precursors of the late-twentieth-century bioethics movement—an affirmation of the individual and the idiosyncratic as opposed to the depersonalization and fragmentation of care implied by clinical pathology, specialism, and reductionist understandings of health and disease. We have experienced a century of recurrent crisis in how we think about medicine and what we expect from it. We seem to have created a system in which material expectations are bound to disappoint, and in which we increasingly and paradoxically keep trying to reach personal (that is, intangible, experiential, and holistic) ends, through technical and mechanism-oriented—reductionist—means.

Another recent bit of media evidence illustrates this point more concretely. *Newsweek* recently featured an article on the genetic causation not only of clinically well-defined mental



illness but also of a bewildering variety of human peculiarities, all construed as less severe manifestations (shadow ailments caused by the presence of one or more “abnormal” genes) of a multi-genic illness.<sup>12</sup> “Idiosyncratic behaviors and personality quirks once thought merely ‘odd’ or ‘interesting’ might be, in a sense, mental illnesses,” the *Newsweek* reporter explained, “a reflection of an abnormality in the brain, and even in the genes.”

Though perhaps at first thought unrelated to the previously mentioned changes in such historically significant institutions as Montefiore and the Pennsylvania Hospital, or to understanding the social place of bioethics, this newsmagazine story illustrates a fundamental and in fact logically related aspect of twentieth-century medicine: its characteristic search for mechanism-based understandings of an ever wider range of human behaviors. This relentless medicalization of both normal and deviant behavior sheds a parallel and supplementary light on a fundamental structural reality in our health-care system: the tendency to ask medicine to do more and more cultural work, while demanding that this cultural work be legitimated in terms of biological mechanism. It is in part a crisis—as illustrated in the *Newsweek* story on the genetic determination of practically everything—of how we legitimate norms, manage deviance, think about ourselves. Behavior, agency, culture itself can be ingenuously reduced to neurochemical mechanisms, even if this determinism continues to dismay those anxious to maintain a place for human agency and individual responsibility.

This structure of linked ideas and institutional relationships poses a number of problems for both historian and bioethicist. Perhaps most fundamental is the way in which ideas, values, and expectations become embedded in institutions, in practices, and in economic relationships and interests. Second is the way in which the concepts and practices of medicine have become increasingly central to the everyday lives of men and women, metastasizing on to the business and editorial as well as the news pages; we seem well on the way to medicalizing not just deviance, but almost every aspect of daily life. Third is the way in which medicine is simultaneously within and outside the market, a paradox that frames today’s most vexing organiza-

tional question: Can the market (as mediated through public advocacy and the political process) prove adequate as a means of distributing clinical equities and outputs, when demand is defined in more than material terms? Can the market produce rational and rationalized (collective) solutions that must be experienced in moral and emotional (individual) terms?

The bottom line, as I have tried to emphasize, is that we cannot remove or isolate value assumptions from the institutional, the technical, and the conceptual in medicine; men and women inevitably express their sense of need and priority in the public sphere. Medicine is negotiated and inevitably political, and, as we have come to understand more generally, the political is cultural. The heated contemporary debate surrounding managed care illustrates in a very concrete way the nature of such interconnections between values and interests. Questions that can be framed as matters of justice and autonomy are at once questions of control and economic gain. Perceptions of right and wrong, of appropriate standards of practice, constitute *de facto* political realities—variables in negotiating choices among rival policies as well as in particular clinical interactions. The widespread assumption, for example, that it is right for government to play a role in providing and regulating health care is a specific historical and ethical, and thus political, reality. And so is the equally pervasive assumption that it is somehow immoral for mere economic calculation to constrain a physician's clinical decision making. Our willingness, in fact, to nurture bioethics similarly constitutes a public recognition of medicine's special moral identity.

But this vague moral consensus cannot mandate a precise and unambiguous social agenda for bioethics. The new enterprise has been charged with a difficult and elusive job. We live in a fragmented yet interconnected world, a world of ideological and social diversity, of inconsistency and inequity, of change and inertia. We cannot discuss relationships among men and women who differ in power and knowledge without acknowledging those inequities: class, geography, gender, race, and education all modify the category *patient*; economic incentives as well as the institutional and intellectual structures of medicine (such as specialty and organizational affiliation) modify

the category *physician*. A growing awareness of such complexities has made bioethics an increasingly labile and self-conscious enterprise. And perhaps a less self-confident one as well: articulating and applying a foundational ethical basis for particular social actions no longer seems an easily attainable goal.

Inconsistent ideas as well as social diversity shape available choices for both physician and patient. Our society has elaborated and internalized not a unified and coherent moral consensus, but rather a world of medical discourse and practice marked by the claims of three competing and not always consistent transcendences. One is the academic research tradition with its worship of the selfless search for knowledge and a widespread faith in its inevitable application. It is a kind of secular millennialism, powerful not simply because it is a source of undifferentiated cultural optimism, but because it is structured into the expectations and hopes of individuals: into the career choices of particular physicians and scientists, into the formation of public policy, and into the status and programs of academic departments and teaching hospitals.<sup>13</sup> Second, and more recent, is the worship of system as goal and ideal, the assumption that the optimum general good is attainable only through an optimum configuration of market and institutional relationships. Finally, of course, is the traditional moral specialness of medicine, respect for physician responsibility and the rights of individual patients—a tradition that can be traced from classical antiquity to contemporary debates over medical care. Each of these claims to transcendence legitimates claims to social authority; all are ceaselessly configured and reconfigured as medicine's technical resources and institutional forms evolve and pose novel research and clinical options. Bioethics has in fact already become a substantive actor in the complex interactions that characterize relations among these realms of value and implicit power.

I have tried in the preceding pages to illustrate a number of the ways in which the moral values that suffuse medicine are historically constructed and situationally negotiated, like every other aspect of culture, and not simply derived from the formal modes of analysis that have historically characterized theology

and moral philosophy (though such delineations of fundamental principle are in themselves an element in the social negotiations that inform and rationalize health care). The formulations of credentialed philosophers and theologians are at once a claim to cultural authority and a factor in the public mediation of social conflict.

#### BIOETHICS AS HISTORICAL SUBJECT

The very existence of a socially visible enterprise called bioethics is a recognition of the recurrent structured conflicts I have tried to illustrate anecdotally. Thus, I began this discussion with particular examples of institutional change because I wanted to emphasize the ways in which the history of bioethics underlines medicine's context dependence, and, in particular, the way in which medicine necessarily embodies a variety of attitudinal and value elements as well as technical capacity and institutional practice.

But this is only one of the ways in which bioethics and history relate. First, from the historian's disciplinary perspective, bioethics is a complex and potentially revealing subject for empirical investigation. Second, and more important, I would contend that although academic history and bioethics have in general followed separate paths, they share a potential community of sensibility, a sensitivity to context and to the relationships among individual perception, social constraint, and the situatedness of human agency. Practitioners of history and bioethics should, finally, be similarly aware of the importance of irony and contingency, of the gap between theory and practice, conscious intent and unforeseeable outcome.

The still-brief history of American bioethics demonstrates just such realities. As a social movement, bioethics developed in the mid-twentieth century as a critical enterprise, a response to felt inhumanities in our system of health care and biomedical research. A response to specific abuses, bioethics has remained practice-oriented; society expects bioethics to solve or at least ameliorate insistently visible problems.

Growing as it has out of a sense of moral outrage, bioethics has had an undeniable impact on everyday clinical realities. Yet

from the historian's perspective, this novel enterprise has played a complex and in some ways ambiguous role. Bioethics not only questioned authority; it has in the past quarter-century helped constitute and legitimate it. As a condition of its acceptance, bioethics has taken up residence in the belly of the medical whale; although thinking of itself as still autonomous, the bioethical enterprise has developed a complex and symbiotic relationship with this host organism. Bioethics is no longer (if it ever was) a free-floating, oppositional, and socially critical reform movement: it is embodied in chairs and centers, in an abundant technical literature, in institutional review boards and consent forms, in presidential commissions and research protocols. It can, that is, be seen as a mediating element in a complex and highly bureaucratic system that must, nevertheless, manage ceaseless technical change. It is not an accident that the bioethical enterprise has routinely linked bureaucracy—committees, institutional regulations, and finely tuned language—with claims to moral stature.

But this functional role implies a structured conflict. By invoking and representing medicine's humane and benevolent, even sacred, cultural identity, bioethics serves ironically to moderate, and thus manage and perpetuate, a system often in conflict with that idealized identity. In this sense, principled criticism of the health-care system serves the purpose of system maintenance. It is such paradoxes of power and consciousness that explain why bioethics needs to think of itself both historically and politically. And in some ways this process has already begun.<sup>14</sup> Bioethics has already enshrined its heroes and villains—Henry Beecher and Josef Mengele—and commemorated its sacred places—Willowbrook, Tuskegee, Nuremberg. In fact, one could argue that the historical stock-taking initiated by bioethics' founding generation is itself an aspect of what might be called institutional consolidation.<sup>15</sup>

Participant histories serve celebratory and mystifying as well as analytical and self-critical ends. History can be used to demonstrate both false consciousness and a celebration of conscience. It is difficult for the committed practitioner not to emphasize her field's positive values and accomplishments, not to see herself on the side of the angels, fighting the good fight

against the routine and unself-conscious abuse of men and women in everyday clinical and research settings. It is equally difficult to see the apparatus of committees and regulations that protect patient rights against the abuses of an impersonal technology as itself a technology. By way of example, let me quote the words of a bioethicist reacting to an earlier version of my present remarks, and in particular to a passage in which I described the bioethical enterprise as in some ways a technology necessarily mirroring the technology it sought to ameliorate. "Bioethics," the indignant reader explained, "in the late twentieth century in American medicine has always championed the rights of the individual patient against the vagaries of the medical system. Its cardinal principles of autonomy, beneficence, non-maleficence, and justice represent the antithesis of technology."<sup>16</sup>

Most contemporaries would not be quite so uncritical in their self-evaluation, yet are still ill-prepared to deal with what I have characterized as the central irony of bioethical success: insofar as it has been accepted by the world of research and clinical practice, it has become a part of those linked enterprises, and thus its every criticism and consequent procedural reform cannot help but constitute an aspect of biomedicine's public moral face.

As a specific empirical subject, moreover, bioethics presents an elusive aspect—as elusive as weighing its ultimate social impact. In part this is because the bioethical enterprise is an aggregate of three not-always-consistent activities. One is the elaboration of formal doctrine, the job of individuals trained to articulate and address normative ethical questions. I refer, of course, to those philosophers and theologians who have sought to create a principled consensus around such policy-defining issues as autonomy, beneficence, and justice. Second is the role of bioethics in mediating day-to-day clinical problems in particular social settings. I have in mind the innumerable contexts in which institutional review boards, government commissions, and the language and ritual of informed consent make practitioners and researchers aware of the rights of patients and subjects. Third is the way in which the bioethical enterprise figures in public discourse, responding in newspapers, periodi-

cals, television, and—in recent years—the Internet to novel dilemmas derived often, but not always, from technological innovation. In this public capacity bioethics reassures, implying that there is a discernible moral order that can be used rationally to manage new and potentially alarming clinical and research choices. It is both ritual and spectacle, acting out the several reassurances of ethical concern, credentialed expertise, and the assumption that fundamental ethical principles can be discerned and applied.

Thus bioethics occupies three distinct (if often overlapping) social spaces. One is academic, formal, discipline- and text-oriented. A second is the hospital and research settings, where bioethics has an institutionalized presence. Third, as I have suggested, is the media. This mosaic of roles and sites of social action makes bioethics both complex in structure and difficult to delineate. This diversity of site, personnel, and function also explains my avoidance of the term “discipline” in describing what I have chosen to call instead the bioethical enterprise: a conglomerate of experts, practices, and ritualized and critical discourse in both academic and public space.

#### BIOETHICS AND THE HISTORICAL SENSIBILITY

I have specified a number of ways in which bioethics and history might share an analytic perspective. First, and perhaps most fundamentally, I would argue, the task of ethical understanding should parallel the historian’s job of cultural reconstruction: both kinds of practitioners should seek—if necessarily imperfectly—to understand a time- and place-specific structure of choices as perceived by particular actors. Second, I would argue that we cannot understand the structure of medical choice without an understanding of the specific histories of medicine and society that have created those choices. This was the argument I hoped to illustrate in my earlier recounting of change in contemporary American hospitals and my emphasis on increasingly reductionist understandings of disease. And third, and perhaps most disquieting, we must historicize bioethics itself. For it is clearly a time-bound enterprise, with complex

relationships to the special world of medicine and to the larger society in which medicine is nurtured and which medicine in part constitutes.

My first point, which seems no more than a truism to a cultural historian, will seem irrelevant or perhaps even philistine to scholars focused on the elucidation of ethical principles abstracted from precise social and institutional contexts—even if motivated by abuses at just such specific sites. Moreover, such formal styles of normative discourse parallel and intensify the historical tradition of medical ethics with its emphasis on the unmediated doctor-patient dyad: one doctor, one patient, one bedside, the paradigmatic vexed case. From the contextually oriented historian's point of view, however, choice is always constrained and structured, a reality to be understood in specific situations, not schematically in terms of logically and morally coherent ends. In this historical and sociological sense, autonomy is a product, not a goal; it is a place-, time-, and system-specific outcome of the interaction between the microcosm of the clinical encounter and the macrocosm(s) of the larger society and the cognitive and institutional world of medicine. This needs hardly be elaborated at a moment in time when many physicians find their clinical interactions limited by managed care providers to fifteen minutes and their diagnostic and therapeutic choices limited as well. Autonomy and agency are constructed and reconstructed in every healing context. There can be no decontextualized understanding of bioethical dilemmas; bioethics is definitionally contextual, as I have argued, finding its origins in the search for particular solutions to visible social problems. A decontextualized approach in bioethics is not simply a matter of disciplinary style; it is a political act.

Discussions of informed consent, for example, that abstract the actors—clinicians, researchers, patients, and “subjects”—from their particular social roles and individual identities are not very helpful and must in fact mystify these social relationships, and, in doing so, legitimate the *de facto* authority of those individuals and institutions doing the “consenting.”<sup>17</sup> At the risk of seeming didactic, let me take a moment to underline the way in which the colloquial use of “consent” as a verb illuminates the ambiguity of routinization in the management of



“autonomy” and “beneficence.” This usage is a syntactical representation of power and comparative powerlessness, of actor and the object of that actor’s actions. To consent a patient is to act out—and legitimate—a reality of social inequality as well as to demonstrate the existence of a self-conscious community of “consenters” well aware of the ritual and hierarchical aspect of this now pervasive ethical mechanism.

I would argue, moreover, that bioethics is not only defined by its context of use but that it cannot be self-aware without an understanding of the history of medicine in the past century: of the roles played by new and specific notions of disease, by the growth of specialism and credentialing, by the siting of the clinical encounter in a technologically rationalized and structured institution instead of the individual home or physician’s office. This point hardly needs elaboration. Bioethics is, or should be, a social and a historical enterprise, for the issues it seeks to mediate are themselves the products of a specific, determining history. Without history, ethnography, and politics, bioethics cannot situate the moral dilemmas it chooses to elucidate. It becomes a self-absorbed technology, mirroring and inevitably legitimating that self-absorbed and all-consuming technology it seeks to order and understand.

But, as I have suggested, it is easier to call programmatically for bioethics to place itself and its tasks historically than to accomplish that task. There is no simple path to understanding the historical place of bioethics but rather a variety of interpretive options, reflecting the interpreter’s point of view and the inherent elusiveness of the subject. The enterprise elicits a diversity of perspectives. To some critics on the Left, bioethics is no more than a kind of hegemonic graphite sprayed into the relentless gears of bureaucratic medicine so as to quiet the offending sounds of human pain. Its ethical positions, this argument maintains, are, in terms of social function, no more than a way of allaying social and legal criticism, and are merely the self-reproaches of a minority of ethically-oriented physicians. Bioethics has, moreover, according to this position, focused too narrowly on the visible problematic instance—on the plug pulled or not pulled, on the organism cloned or the cloning interdicted—and avoided consideration of less easily dramatized

policy debates and mundane bedside dilemmas. And, finally, these critics contend, it is not surprising that in a bureaucratic society we have created a cadre of experts and a body of knowledge to provide a soothing measure of humanity, certified and routinized.

To its sophisticated practitioners and advocates, on the other hand, bioethics is a humane change agent, an important mechanism for mediating technological and institutional change, a kind of software that facilitates the adaptation of novel varieties of hardware. It is, the argument states, a genuine constraint, a substantive actor in a complex renegotiation of everyday medical practice; bioethics has, similarly, influenced the conduct of clinical research with human and animal subjects. One need only point to the creation of research guidelines for human and animal subjects, to the existence of institutional review boards, and to good-faith attempts to make informed consent a reality. Even if an unfettered individual autonomy may be an unrealizable ideal, the assumption nevertheless that there is such a thing contributes to a viable framework for thinking about transcendent value, constitutes in itself a resource in the complex negotiations that determine and constrain individual and institutional choice. Bioethics has also played a constructive role in the public discourse surrounding clinical medicine and biomedical innovation, a media discourse that is necessarily focused on particular problems as spectacle yet in such perception-altering acts changes our structure of political choice.<sup>18</sup> Perhaps most important, bioethics expresses the widely felt social—and thus political—assumption that medicine is and must be more than a sum of technical procedures and market transactions. It promises solutions to human dilemmas beyond the impersonal profit-maximizing choices of the market or the ultimately elusive if seductive dreams of technological utopianism.

#### HISTORY, CONTINGENCY, AND BIOETHICS

Just as the three principles of value in real estate are location, location, location, for history they are context, context, and context. And irony and contingency are implicit in a contextual style of analysis; history, like life itself, is filled with unintended

consequences. But in one respect historians are more fortunate than bioethicists: no one expects them to solve emergent social problems. The bioethical enterprise, on the other hand, originated, as we have seen, as a response to such perceived problems and continues to offer not just analysis of but solutions to them.

Yet the most profound of such problems are, in their nature, unsolvable. We are well aware that there is no ultimate solution for pain and death, no way to explain the brutal randomness with which suffering is distributed. These are aspects of the human condition. Some other issues are perhaps less obvious. There is also no easy solution, for example, to the way inequalities of social identity reenact themselves in medical care. Another paradox grows out of our natural yet contradictory desire for cure and care, for technological efficacy with a human face. But care and cure are not easily linked in one context; the historical circumstances that produce the laboratory's undeniable achievements also produce the bureaucracy that intimidates, fragments, and distances. A parallel conflict grows out of the difference between interest as defined by the individual and interest as defined by the collective; a test or procedure that can benefit one individual might be irrational from the social system perspective. Ours is a health-care system, moreover, that has consistently demonstrated the ability to incorporate the critically and morally oppositional and make it an aspect of the system itself. And this, perhaps, is the ultimate irony of bioethics' history: the persistent yet perhaps illusory quality of our desire to routinize the humane, to formulate and safeguard timeless values in a world of ceaseless change, social inequality, and utopian laboratory expectations.

#### ENDNOTES

<sup>1</sup>Esther B. Fein, "Region to get Clinics giving Specialty Care," *New York Times*, 9 February 1998, B1.

<sup>2</sup>Andrea Gerlin, "A Venerable Phila. Hospital Charts a New Course," *Philadelphia Inquirer*, 1 February 1998, D1; for background on the sale of the Institute of the Pennsylvania Hospital, see Karl Stark, "Talk Isn't Cheap, Forcing Changes in Psychiatry," *Philadelphia Inquirer*, 14 September 1997, E1.

<sup>3</sup>Hahnemann was founded as America's premier homeopathic training institution in 1848, and the Medical College of Pennsylvania is better known to historians by its original appellation: the Woman's Medical College, a pioneer institution founded in 1850. In 1993, the two schools announced their intention to merge under the auspices of the Pittsburgh-based Allegheny Health, Education, and Research Foundation; they admitted their first class two years later. Cf. Naomi Rogers, *An Alternative Path: The Making and Remaking of Hahnemann Medical College and Hospital of Philadelphia* (New Brunswick and London: Rutgers University Press, 1998); Gulielma F. Alsop, *History of the Woman's Medical College: Philadelphia, Pennsylvania, 1850–1950* (Philadelphia: J. B. Lippincott, 1950).

<sup>4</sup>Robert Pear, "Medical Research to Get More Money from Government: An Investment in Health," *New York Times*, 3 January 1998, A1.

<sup>5</sup>Pam Belluck, "Heartache Frequently Visits Parents with Multiple Births," *New York Times*, 3 January 1998.

<sup>6</sup>*Time*, 11 January 1999.

<sup>7</sup>Which is not to say that such variables are not significant. See, for example, Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Morris J. Vogel, *The Invention of the Modern Hospital: Boston, 1870–1930* (Chicago and London: The University of Chicago Press, 1980); Dorothy Levenson, *Montefiore: The Hospital as Social Instrument, 1884–1984* (New York: Farrar, Straus & Giroux, 1984).

<sup>8</sup>See, for example, William Munk, *Euthanasia: Or, Medical Treatment in Aid of an Easy Death* (London: Longmans, Green, and Co., 1887).

<sup>9</sup>Cf. Allan M. Brandt and Paul Rozin, eds., *Morality and Health* (New York and London: Routledge, 1997).

<sup>10</sup>Although it is conventional to see the bioethics movement as having its late-twentieth-century origins in Nuremberg, it is equally conventional to see it crystallizing as a self-conscious movement in the 1960s as, in part, a response to those social currents that produced a more general sensitivity to individual rights—of women, prisoners, and sexual and racial minorities—and as an anti-authoritarian skepticism toward credentialed expertise. See, for a first generation of bioethics history, Albert R. Jonsen, *The Birth of Bioethics* (New York and Oxford: Oxford University Press, 1998); David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991); George J. Annas and Michael A. Grodin, eds., *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation* (New York and Oxford: Oxford University Press, 1992).

<sup>11</sup>I do not mean to imply that medical practice has in fact been invariably humane, caring, and selfless over time, but rather that a commitment to this ideal has always been part of the profession's formal corporate identity.

<sup>12</sup>Sharon Begley, "Is Everybody Crazy?" *Newsweek*, 26 January 1998, 51–55.

<sup>13</sup>For an argument emphasizing the nineteenth-century roots of such discipline-structured patterns of value and action, see Charles E. Rosenberg, *No Other*

*Gods: On Science and American Social Thought*, 2d ed., rev. (Baltimore and London: The Johns Hopkins University Press, 1997).

<sup>14</sup>Cf. Jonsen, *The Birth of Bioethics*; Rothman, *Strangers at the Bedside*; George Weisz, ed., *Social Science Perspectives on Medical Ethics* (Philadelphia: University of Pennsylvania Press, 1990); Albert R. Jonsen, ed., "The Birth of Bioethics," Special Supplement, *Hastings Center Report* 23 (1993); Ruth R. Faden and Tom L. Beauchamp, in collaboration with Nancy M. King, *A History and Theory of Informed Consent* (New York and Oxford: Oxford University Press, 1986).

<sup>15</sup>For a deeply informed guide to this history by an influential participant, see Jonsen, *The Birth of Bioethics*.

<sup>16</sup>Personal communication, Sheldon Lisker, M.D., to the author, 1 February 1999.

<sup>17</sup>For an illuminating case study, see Renee R. Anspach, *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery* (Berkeley, Los Angeles, and London: University of California Press, 1993).

<sup>18</sup>The recent media achievement of Dr. Jack Kevorkian in making end-of-life issues a public topic is a case in point.